Parliamentary and Health Service Ombudsman

Complaints about the NHS in England: Quarter 3 2018-19

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Our role

We make final decisions on complaints that have not been resolved by the NHS in England and UK government departments, and some other UK public organisations. We do this independently and impartially.

We are an independent public ombudsman service. We are not part of government, the NHS in England or a regulator. We are neither a consumer champion nor an advocacy service.

The purpose of this report

This report presents statistics on complaints about the NHS in England from October to December 2018 (Quarter 3 2018-19). It includes data about the NHS complaints we received, assessed and investigated during this period.

We have not presented the quarterly data on complaints about UK government departments and other organisations we investigated due to the relatively lower volumes involved, but we do publish this data annually.

Our data

There are some caveats to the data we have included in this report that anyone relying on it for research or other purposes should note. In 2016-17, we introduced a new casework management system (CMS), although some of our older cases are still held in our previous system, Visual Files (VF).

Due to the different ways of recording data on the two systems we have used only data from our new CMS when presenting our analysis of the issues people complain about. This ensures consistency and will enable us to carry out trend analysis over time. The proportion of cases we investigated recorded in our old system that we closed in Quarter 3 was 2%, and will continue to decline.

We have included data from both systems when we explain the recommendations we have made, to give as full a picture as possible of the resolutions of cases that have been concluded in this period.

We undertake a full data audit at the end of each financial year, which can lead to some reclassification of a small number of cases. This means that the data presented in our quarterly reports may differ slightly from our annual data.

Data from Quarters 1 and 2 which we have presented in this report included cases investigated by the PHSO and the Local Government and Social Care Ombudsman's (LGSCO's) Joint Working Team. These made up 7% (56) of the investigations we closed during our first two quarters. However, in order to provide a clearer picture of the cases which come solely under PHSO's remit we will be removing joint working cases from our data from Quarter 3 onwards.

Our process

We are the final stage in the process for people to resolve complaints about the NHS in England, UK government departments and some other public organisations. We have a three-step process for dealing with complaints.

Step one: initial checks

We conduct initial checks to work out whether the complaint is one we are able to look at. If it is not ready for us to look at or if our checks show that we cannot help, we will explain this and signpost people to another service that might be able to help with the complaint.

Step two: assessment

Here we look in more depth at what happened and decide whether we should investigate the complaint, or whether we can resolve it without a full investigation. There are some cases that we cannot look at, for example there is normally a limit on the time between when the complainant first became aware of the problem and when they bring it to us, and we also need to consider whether legal action would be more appropriate.

Step three: investigation

If after an assessment we decide that it is appropriate, we then begin a formal investigation. When we complete an investigation, we may fully uphold, partly uphold or not uphold the complaint. If we fully or partly uphold the complaint, we can make recommendations to the organisations involved.

Not all of the complaints that come to us go through our whole process. We seek to resolve complaints as early as possible in the process meaning that we can provide answers to more people without them having to wait until the conclusion of a formal investigation.

Step one: initial checks

During Quarter 3 we completed our initial checks on

5,394

health complaints, including complaints continued from the previous quarter.

These were progressed in the following ways:

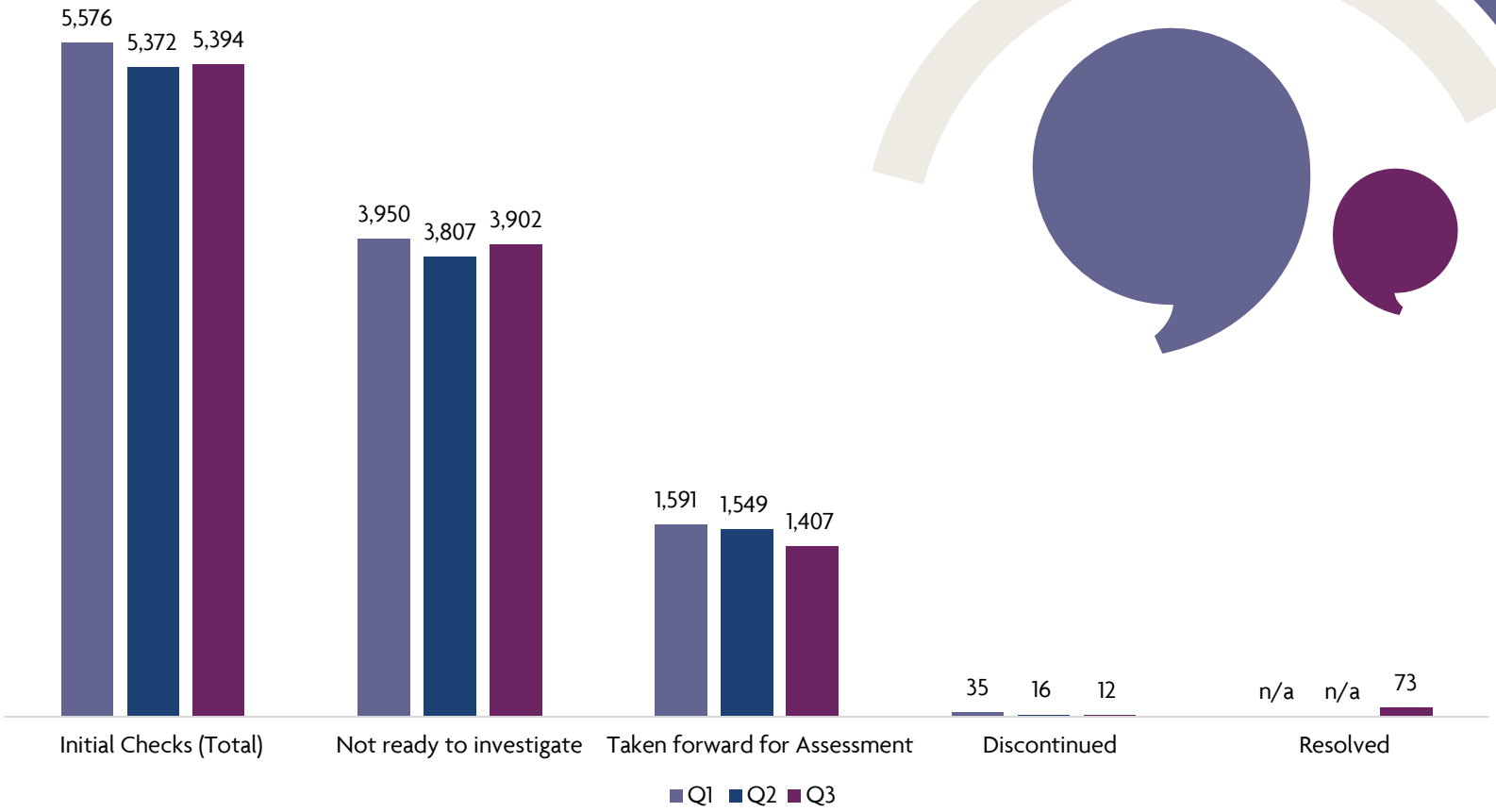
3,902 We gave information on how to make a complaint to the NHS in England, or other public organisations, or signposted to another organisation that would help.

1,407 We referred these complaints for more in-depth consideration (an assessment – step two in our process).

12 We closed these complaints because they were not pursued by the people who brought them following their initial approach to us.

73 We were able to resolve these complaints without the need for an assessment by working with the organisation complained about, or closed the complaint as we were unable to reasonably achieve anything further for the complainant following our initial checks.

Chart 1: Intake cases, Quarter 1 - Quarter 3 2018-19



Resolving complaints

During Quarter 3, we introduced new methods at the first step of our process for dealing with complaints to resolve cases more swiftly without the need for a full investigation. The case summaries below are examples of our resolution work at the first step of our complaints process during Quarter 3.

Case summary 1

Mr X complained about the service he received from his dental practice. He said he received an invoice from the Practice through the post for NHS dental treatment, which he said he had already settled in full in person. Mr X said he did not have a receipt to prove this but was adamant that he had paid the bill in full and believed the Practice were 'bullying' him in an attempt to receive extra money. The Practice had stated in their letter that they would pass his debt on to a debt collecting agency if the money was not paid.

We looked into what had happened and considered it likely that the Practice had made an error by undercharging Mr X on the day and not following this up at an early stage when they realised they had made an error. We contacted the head office of the dental franchise and discussed this with their complaints team. As a result the provider agreed to waive the outstanding charge and to confirm this to Mr X in writing along with an apology and confirmation that no further action would be taken.

Case summary 2

Mr H complained about the service he had received from a pharmacy. He said the Pharmacy told him initially that they did not have the medication he had been prescribed. They subsequently contacted him to say that they did have the medication. However, after Mr H had collected his medication he discovered that the medication was out of date and had to return it to the Pharmacy.

Mr H complained to the Practice and they provided an apology, an explanation of action taken to prevent this happening again and an offer of a goodwill payment to Mr H for the inconvenience and stress he experienced. As Mr H was not satisfied with the payment offered we contacted the Pharmacy and were able to agree an increased amount that we considered a reasonable offer in the circumstances. We contacted Mr H to tell him this and Mr H agreed and the complaint was successfully resolved.

Step two: assessment

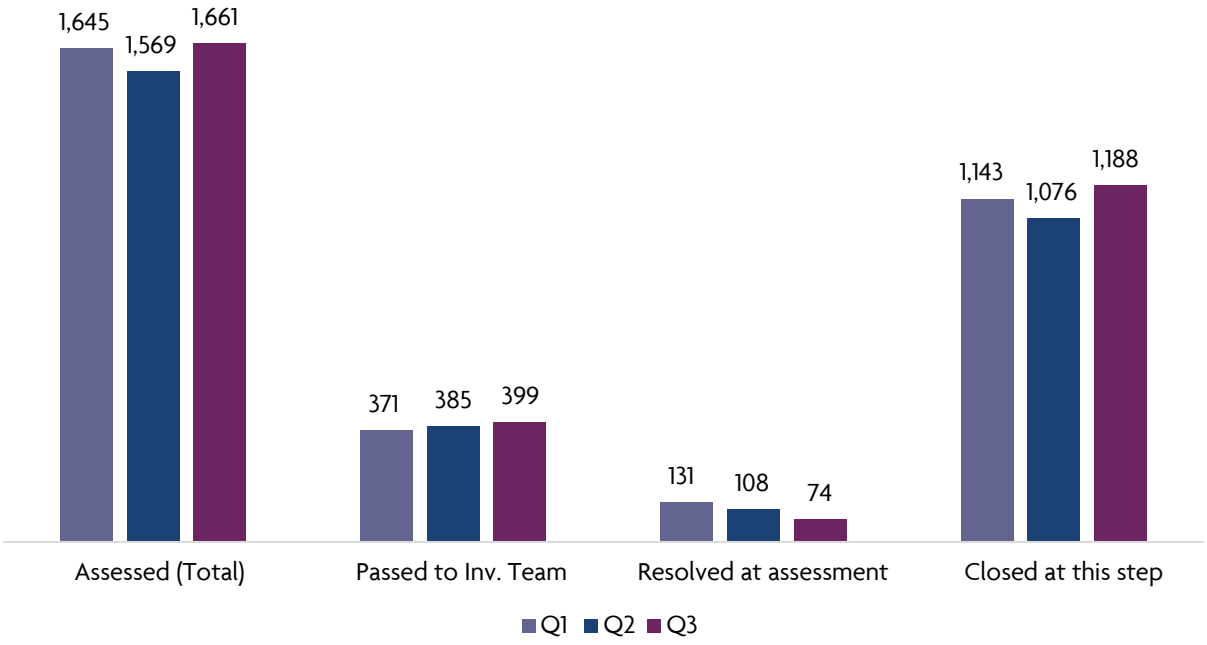
These were progressed in the following ways:

399 We passed these complaints to our investigations team – step three in our process. This accounted for **24%** of all the complaints we dealt with at this step.

74 We were able to resolve these complaints without the need for an investigation, by working with the organisation complained about.

1,188 We closed the remainder at this step for a variety of reasons, for example, because the complainant asked us to.

Chart 2: Assessment cases, Quarter 1 - Quarter 3 2018-19

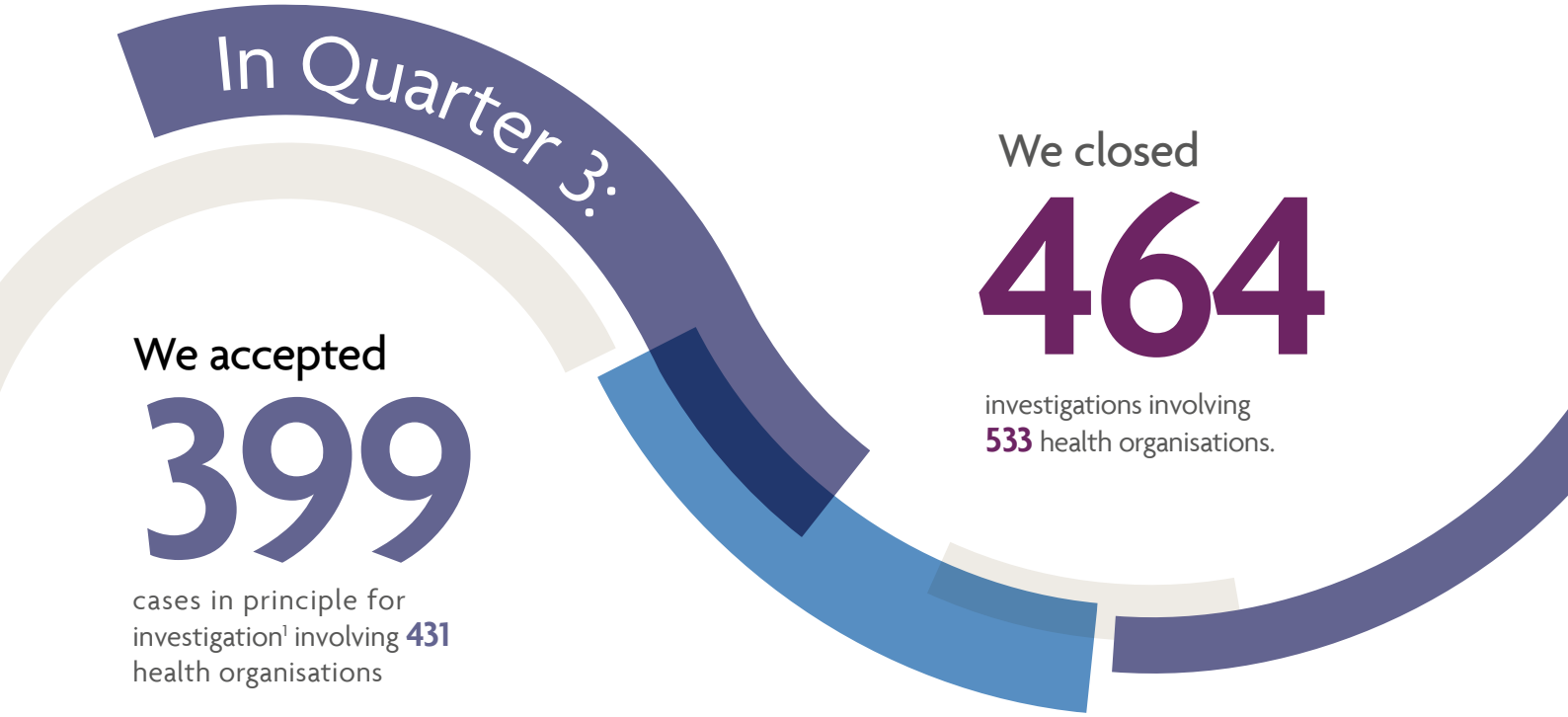


Key findings: Initial Checks and Assessments in Quarter 3 2018-19

The number of initial checks we completed on health complaints was **5,394** in Quarter 3 compared to **5,372** in Quarter 2, and **5,576** in Quarter 1.

The number of health complaints we assessed was **1,661** in Quarter 3 compared to **1,569** in Quarter 2, and **1,645** in Quarter 1.

Step three: investigation



[3] Our casework management system records the date on which we have proposed to investigate a case rather than when we confirm an investigation. As our quarterly data provides a snapshot of our casework flow at a given time, in some cases following comments from the parties, we may decide not to investigate.

Of the cases we investigated:

190 (41%) were either fully upheld (**36** or **8%**) or partly upheld (**154** or **33%**).

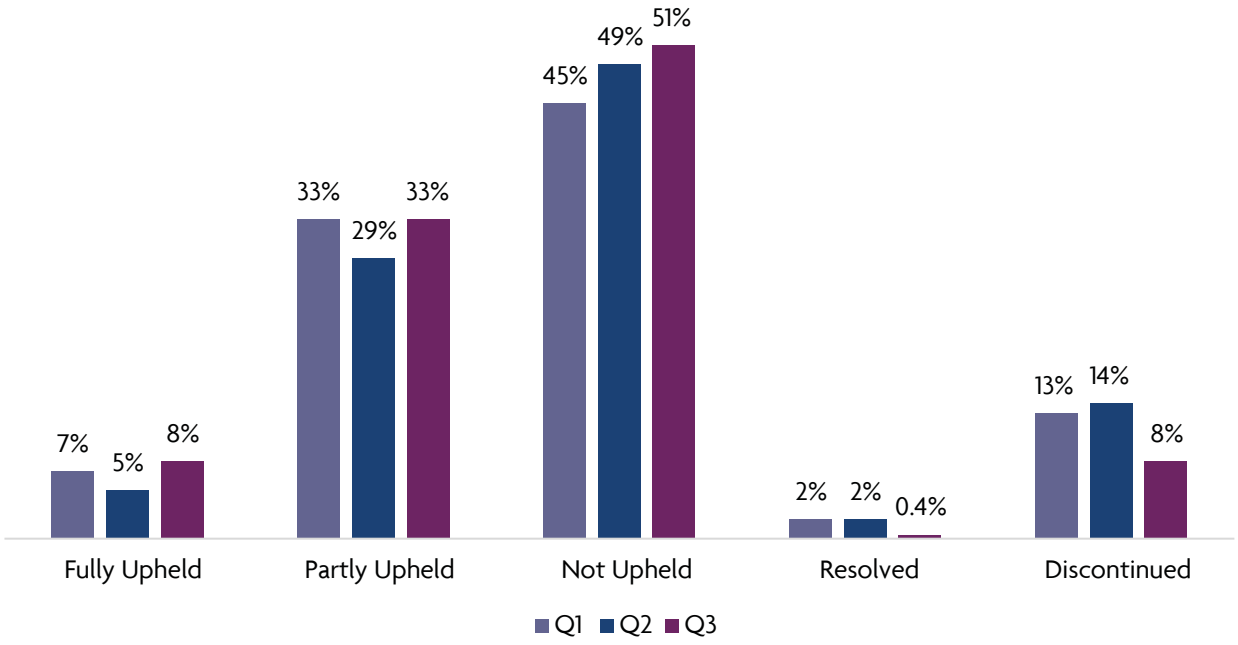
236 (51%) were not upheld.

2 (0.4%) were resolved before the investigation was concluded.

36 (8%) were ended for other reasons, for example because the complainant asked us to[2].

[2] Please note percentages may not add up to 100% due to rounding.

Chart 3: Decisions made at investigation, Quarter 1 - Quarter 3 2018-19



Key findings: Health investigations in Quarter 3 2018-19

We accepted **399** cases in principle for investigation involving **431** health organisations compared to **385** cases involving **426** organisations in Quarter 2, and **371** cases involving **393** health organisations in Quarter 1.

We closed **464** investigations involving **533** health organisations compared to **440** investigations involving **512** health organisations in Quarter 2, and **400** investigations involving **459** health organisations in Quarter 1.

We fully or partly upheld **41%** of the cases we investigated compared to **35%** in Quarter 2 and **40%** in Quarter 1.

Recommendations

When we identify failings, we make recommendations to organisations to put things right. In most cases these are accepted by the organisations in question. On the rare occasions they are not accepted, we can highlight these to the Public Administration and Constitutional Affairs Committee in the UK Parliament.

Each case can have more than one recommendation. In Quarter 3 for complaints about the NHS we upheld or partly upheld, we made the following recommendations to organisations to put things right:

115 formal apologies.

80 payments to make up for financial loss or to recognise the impact of what went wrong. This totalled **£67,714.51** from the NHS organisations we investigated [3].

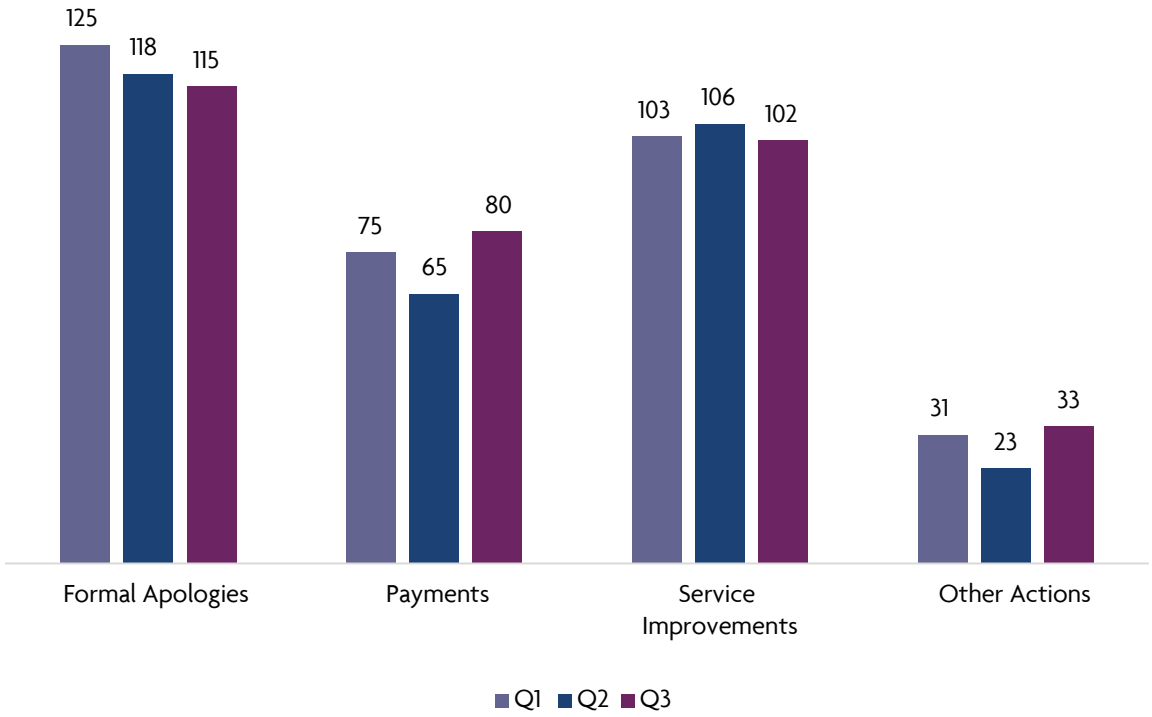
102 service improvements, such as changing procedures or training staff.

33 other actions to put things right. For example, asking a GP practice to correct errors in medical records.

[3] Please note that in our report on recommendations for Quarter 2 2018-19 there was a health service compensation payment where the final value had not been determined at the time of writing. The organisation have subsequently calculated and refunded an amount of £10,920.79 in October 2018. This is not included in the figure for payments in Quarter 3.

Additionally, one recommendation made in Quarter 3 for a non-financial loss compensation of £500 is not included as the complainant decided not to accept the payment.

Chart 4: Recommendations made, Quarter 1 - Quarter 3 2018-19



Driving service improvements

When we find something has gone wrong and not been put right, as well as achieving a remedy for the individual we will identify areas for service improvement. One of the main reasons people bring complaints to us is to prevent the same things happening to anyone else. When we see that an organisation can make service improvements, we will often ask them to produce an action plan to address the failings we identified within an agreed time frame. The case summaries below, from investigations closed in Quarter 3, are good examples of this, which clearly set out the actions taken to improve. We usually expect organisations to tell us what they will do to improve their service, as each organisation is set up differently. However, we also have guidance on writing action plans, which sets out what we expect to see.

Case summary 1

In 2013 we published our Time to Act insight report which helped to put sepsis awareness on the national health agenda. We have continued to share insight and learning from our casework on sepsis prevention to improve public services, most recently in September 2018 when an investigation we published found a 26-year old woman's death from sepsis was avoidable. However, there is still room for improvement: the case summary below shows we continue to receive complaints about sepsis treatment and illustrates the action we required the organisation to take to improve.

Ms K complained about the care and treatment her late mother received from three medical organisations (the GP practice, South Western Ambulance Service NHS Foundation Trust, Torbay and South Devon NHS Foundation Trust). Ms K stated the GP failed to carry out a thorough examination or discuss her mother's condition with her in a timely manner, that the ambulance service delayed in sending an ambulance, and that the Trust failed to reach a timely diagnosis which could have saved her mother's life.

We found the Practice failed to act in line with GMC guidance by not taking a full medical history and fully recording this in the notes when Ms K's mother first attended the Practice complaining of back pain. However, as it had already apologised and taken appropriate steps to prevent similar failings in the future, no further action was necessary to put these failings right. Similarly, our investigation found the ambulance service failed to handle Ms K's initial call to the service appropriately, but as the ambulance service had already apologised, acknowledged shortcomings and carried out a full investigation, we were satisfied that this was a suitable remedy and that no further action was necessary.

We found that although Ms K's mother's death was unavoidable, the staff in the Emergency Department at the Trust failed to treat severe sepsis in a timely manner in line with relevant guidance. We recommended they made a payment of £500 to acknowledge the distress caused and produce an action plan to ensure a robust system and sepsis pathway was in place to prevent future failings of a similar manner.

In response, the Trust put together the action plan below to help prevent a repeat of the failings we identified in our investigation:

Issue	Current state / further actions	Monitoring	Responsible person
Sepsis pathway review	The sepsis pathway is reviewed according to Trust guidance, and when new national guidance is received. The sepsis guidelines were reviewed and updated in 2014, 2015, 2017, 2018.	Clinical policy guidelines are overseen by the Trust Clinical Effectiveness department. The responsible clinicians are asked to review the guidelines when the guidelines are within 3 months review date, or when new National Guidance is received. Any clinical amendments are overseen by the clinical teams and by the Trust Quality Improvement Group.	Clinical Effectiveness Department Manager
Sepsis pathway awareness	Posters advertising the sepsis pathway are displayed in clinical areas in the Emergency Department and updated following policy changes. Further awareness of the pathway will take place through departmental daily safety briefings during Feb / March 2019.	Evidence via daily safety briefings	Matron and Consultant Clinical Lead
Recognition of Sepsis	The electronic patient system used in the Emergency Department includes a prompt to consider sepsis if patients' Early Warning Score (resulting from vital signs) reach the set threshold.	This information forms part of the Emergency Department performance metrics and is reviewed as part of the monthly Clinical Governance meeting process.	Consultant Clinical Lead

In response, the Trust put together the action plan below to help prevent a repeat of the failings we identified in our investigation: (continued)

Issue	Current state / further actions	Monitoring	Responsible person
Time to antibiotics	Audits of time to administer antibiotics are undertaken at intervals and these results are reported through the Emergency Department Clinical Governance meetings, and are also available for review at the Quality Improvement Group. Sepsis champions will now undertake monthly sample audits which will be reported through the department Clinical Governance meetings.	Monthly Emergency Department Clinical Governance meetings Quality Improvement Group	Consultant Clinical Lead
Sepsis champions	Appoint sepsis champions amongst existing staff members in the Emergency Department. Champions will provide a supporting function to all staff in timely completion of the sepsis pathway.	Champions and role specifics to be identified during February and March 2019.	Matron and Consultant Clinical Lead
Clinical observations	The electronic system in ED records the patients' vital signs and the resulting Early Warning Score is clearly displayed on the electronic boards in the department. These are automatically updated when subsequent observations are entered onto the system. Further action is planned to audit the appropriate timing of 2nd observations according to Trust policy.	Sample audit of a minimum of 10 records each week to be undertaken by the senior nurse leading the shift. Results to be reported to the Emergency Department Clinical Governance meeting, and made available to the Quality Improvement Group.	Matron and Consultant Clinical Lead

Case summary 2

In December 2015 we published our Breaking down the barriers insight report, focusing on the particular barriers that older people and their carers face when complaining, and using our casework to illustrate the issues older people experience in health and social care. We have continued to highlight these issues in case summaries we published in February, and in November 2018.

The case summary below concerns an older patient admitted to hospital following a fall. After our investigation identified mistakes in the assessment and management of pain, we recommended the Trust set out the actions they would take to prevent the same mistakes happening again.

Mrs E complained on behalf of her late mother that University Hospitals Leicester NHS Trust failed to provide her with the care she needed after she was admitted following a fall at home. Specifically, she complained that the nursing care was poor, that her mother was not physically handled as she should have been, that her nutrition and medication were not managed appropriately, and that staff showed no compassion. She also complained that responses to her complaint were not open and transparent.

We partly upheld Mrs E's complaint. Although the majority of care provided was in line with standards and accepted clinical practice, we identified mistakes in the assessment and management of pain so recommended the Trust write to Mrs E to apologise and produce an action plan setting out how it intended to improve services which the Trust should also share with the Care Quality Commission.

The Trauma and Orthopaedic Team at the Trust responded with an action plan addressing the issues identified in our investigation which is included below:

Root Cause/ Contributing Factor	Agreed Action	Evidence Required	By whom	By when
Pain Management	If a patient is unable to take their medication orally, this needs to be documented on the Electronic Prescribing and Medicines Administration (EPMA) system and escalated to the ward doctor for alternative drug or route to be prescribed and assessed.	On-going and monitored through matrons and pharmacy audits (nursing metrics and medication safety thermometer).	Nursing and medical team	31 October 2018
Pain assessment	a) All patients to be assessed as per Early Warning Score (EWS) policy using the E-Observations system. Pain score to be completed as mandatory requirement. b) All instances of uncontrolled pain to be reported to the medical team by the responsible staff nurse.	a) Monthly safety thermometer and medication safety thermometer and metric's audits. b) Monthly metrics and safety thermometer.	a) Nursing and medical team b) Nursing Team	Complete
Reduced senior medical cover	All patients with fractured Neck of femur to be reviewed in the week by the consultant ortho-geriatrican team who provide a care of the elderly service to review the patients and their existing medical conditions.	Review of Medical notes.	Nursing and medical team	30 September 2018

The Trauma and Orthopaedic Team at the Trust responded with an action plan addressing the issues identified in our investigation which is included below: (continued)

Root Cause/ Contributing Factor	Agreed Action	Evidence Required	By whom	By when
Inappropriate administration route for analgesia	Paracetamol is to be administered intravenously rather than orally, to improve effect.	Metric's Dashboard	Nursing and medical team	Complete
Lack of MDT communication surrounding pain management.	Case to be discussed at the orthopaedic mortality and morbidity review meeting.	Minutes from the Monthly metric's meeting.	Nursing and medical team	Complete
Increased vacancy and poor skill mix of nursing workforce. Lack of understanding and education surrounding frailty.	Ward team to undertake frailty and assessment training.	Improved recruitment and training records	Nursing and medical team	31 October 2018

Investigations by organisation type

Sometimes, we receive individual complaints that involve more than one organisation. Table 1 shows the organisations involved in the health cases we completed our investigations into in Quarter 3. Case outcomes recorded as 'Other' refer to cases we investigated that we ended for a variety of reasons, for example because the complainant did not wish to pursue the case further.

Table 1: Health investigation outcomes by organisation type, Quarter 3 2018-19

Organisation type	Fully or partly upheld	Not upheld	Other	Total
Hospital and community health services	124	169	26	319
Primary care services	39	61	12	112
Clinical Commissioning Group	10	11	9	30
Independent provider	12	15	5	32
NHS England organisations (local area team and commissioning region)	3	16	2	21
Ambulance Trust	2	9	1	12
Special Health Authority	2	4	1	7
Total	**192**	**285**	**56**	**533**

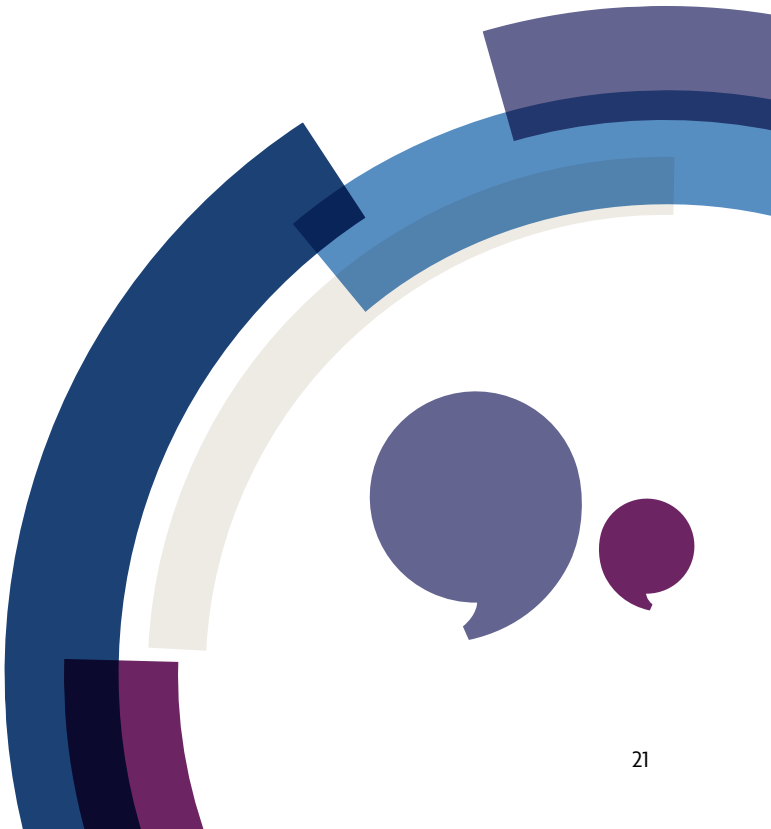
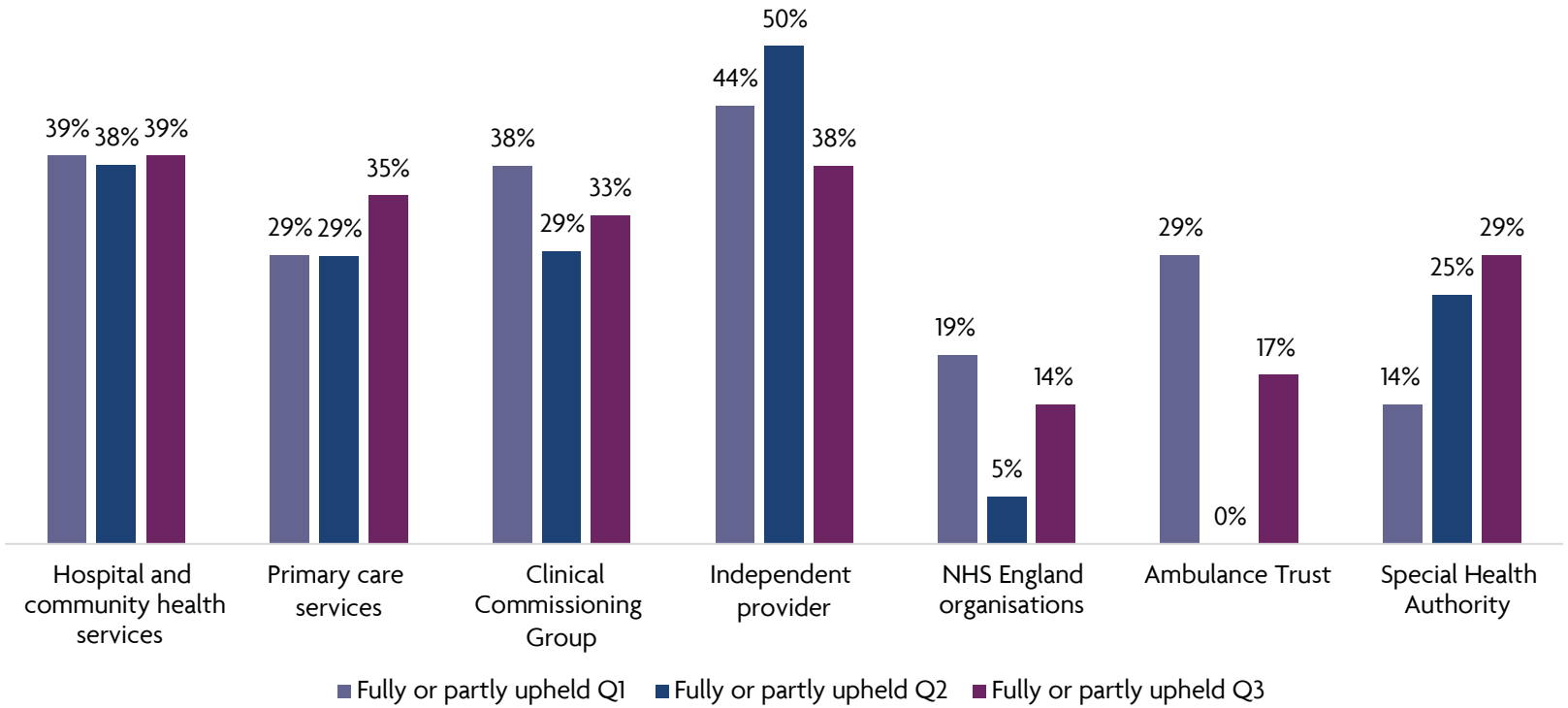


Chart 5 shows the uphold rate for organisations we investigated in Quarter 3 2018-19.

It is important to note the low numbers of investigations for some of these settings means that only a small change in the decisions we make will make a big difference to the uphold rate.

Chart 5: Health investigation outcomes by organisation type, Quarter 1 - Quarter 3 2018-19



Hospital and community health services

The area in which we saw the most complaints about healthcare provision in Quarter 3 was in hospital and community health services. Chart 6 shows the five most common types of service within hospital and community health service complaints that were fully or partly upheld during Quarter 3:

Chart 6: Upheld complaints by type of service in hospital and community health services, Quarter 1 - Quarter 3 2018-19

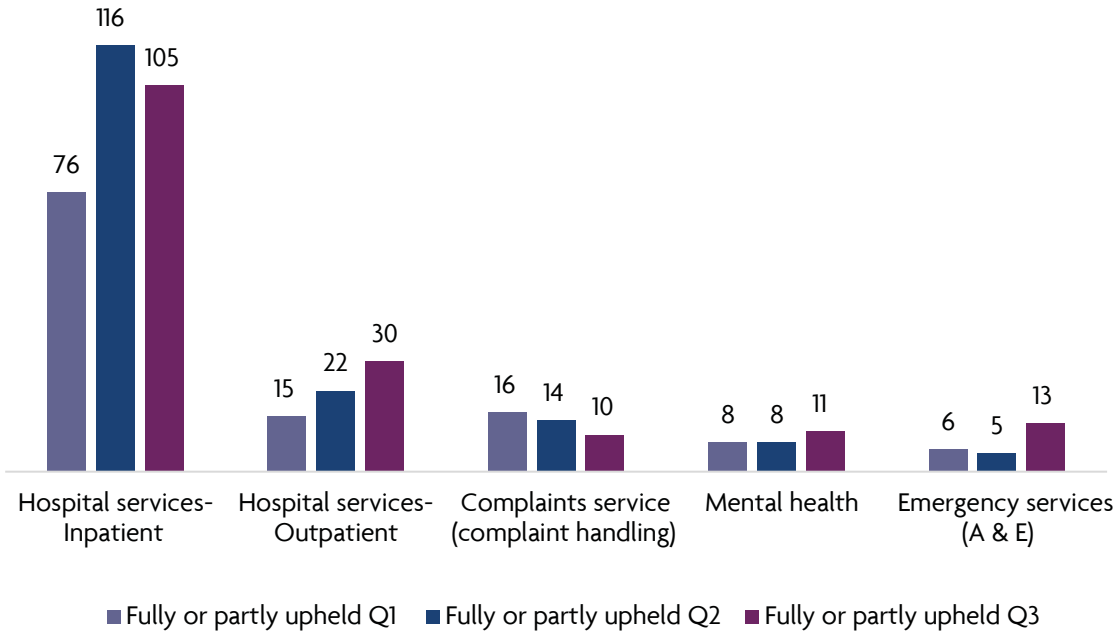
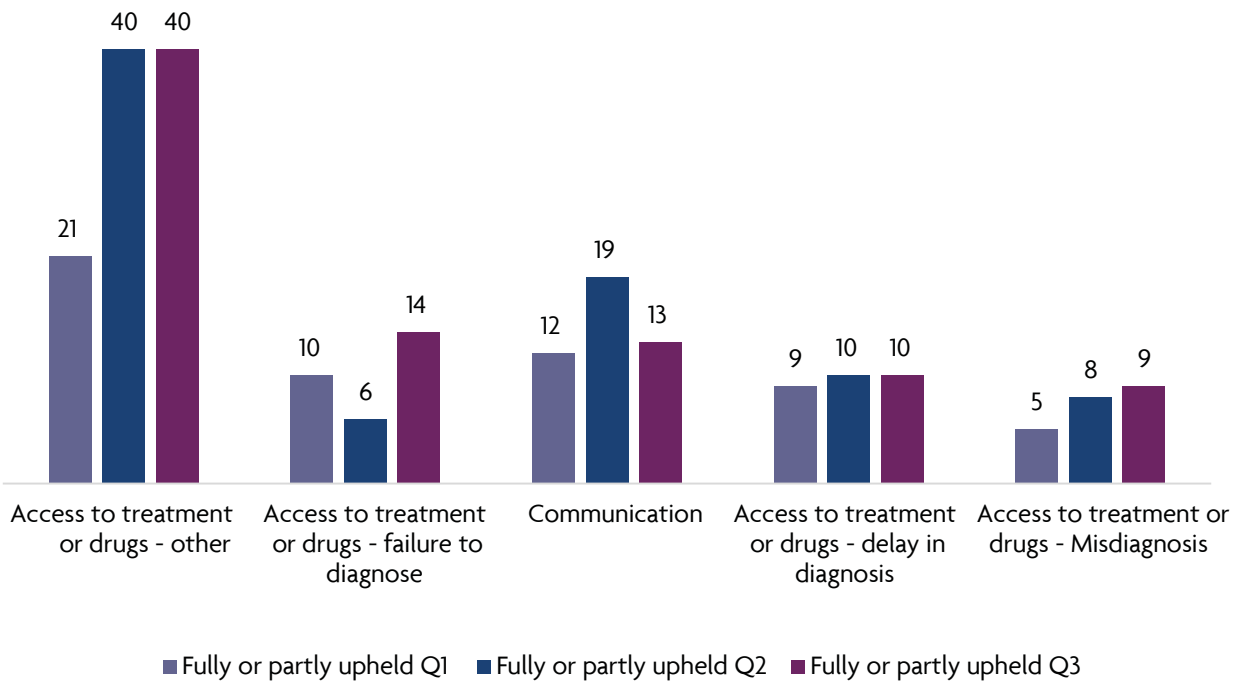


Chart 7 shows the five most common complaint issues for cases we fully or partly upheld in Quarter 3 in hospital and community health services. These issues were:

- **Access to treatment or drugs – other:** 'Access to treatment or drugs' includes eight sub-categories covering issues around diagnosis, referrals and visits. This 'other' category is used to record any issues that fall outside these more specific categories.
- **Access to treatment or drugs - failure to diagnose:** These were complaints about a misdiagnosis or a failure to diagnose a condition that the complainant believed was not acceptable.
- **Communication:** Communication issues could include how clinical decisions have been explained and whether the implications were made sufficiently clear.
- **Access to treatment or drugs – delay in diagnosis:** These are complaints where there has been an unreasonable delay in diagnosing an illness or starting treatment.
- **Access to treatment or drugs - Misdiagnosis:** This category refers to an incorrect diagnosis that led to incorrect or delayed treatment

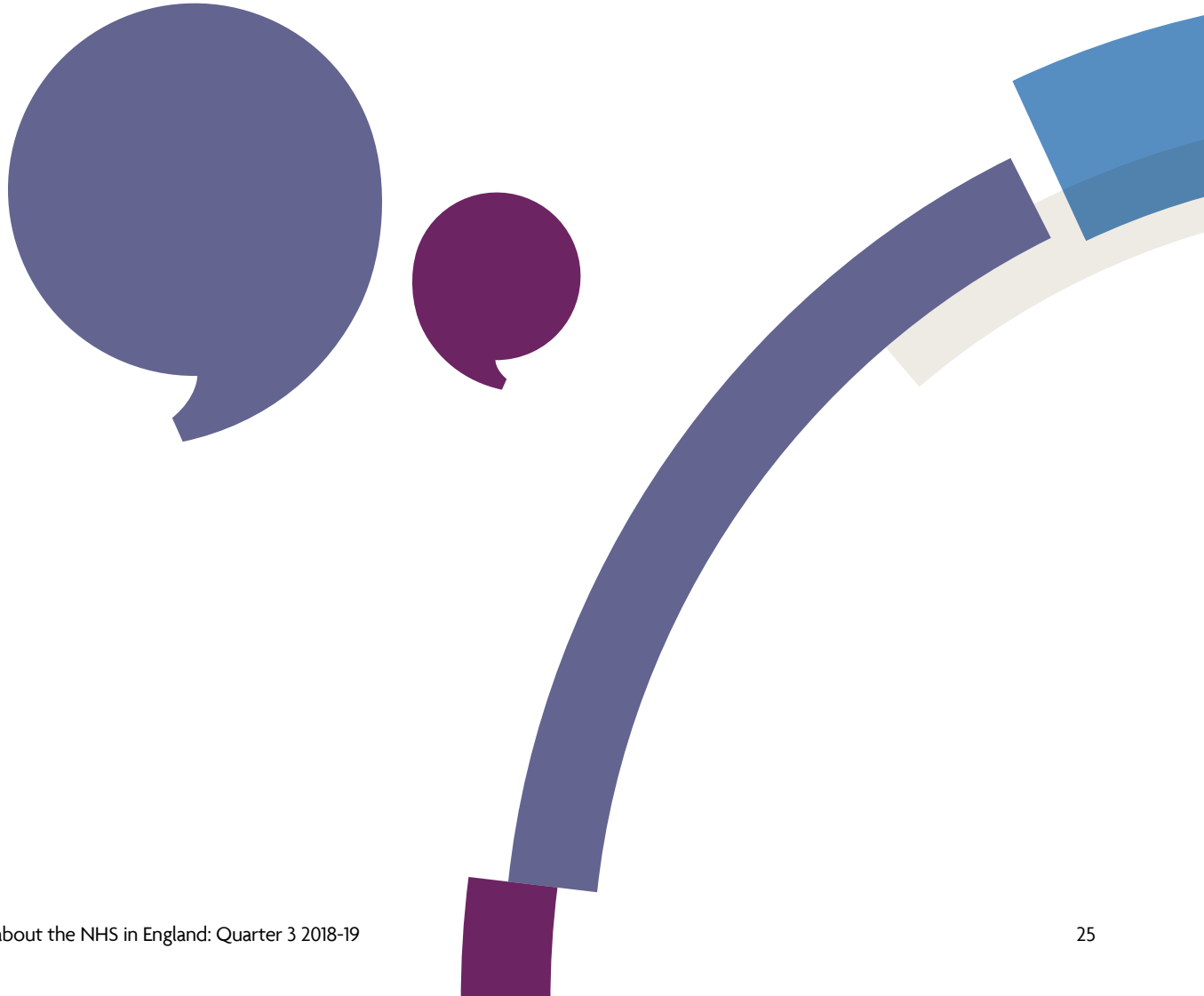
Chart 7: Upheld complaints for hospital and community health services by complaint issue, Quarter 1 - Quarter 3 2018-19



Key findings: Hospital and community health service complaints

The largest proportion of complaints we fully or partly upheld in hospital and community services in Quarter 3 was in inpatient services. The number of complaints we fully or partly upheld in inpatient services was **105** in Quarter 3 compared to **116** in Quarter 2, and **76** in Quarter 1.

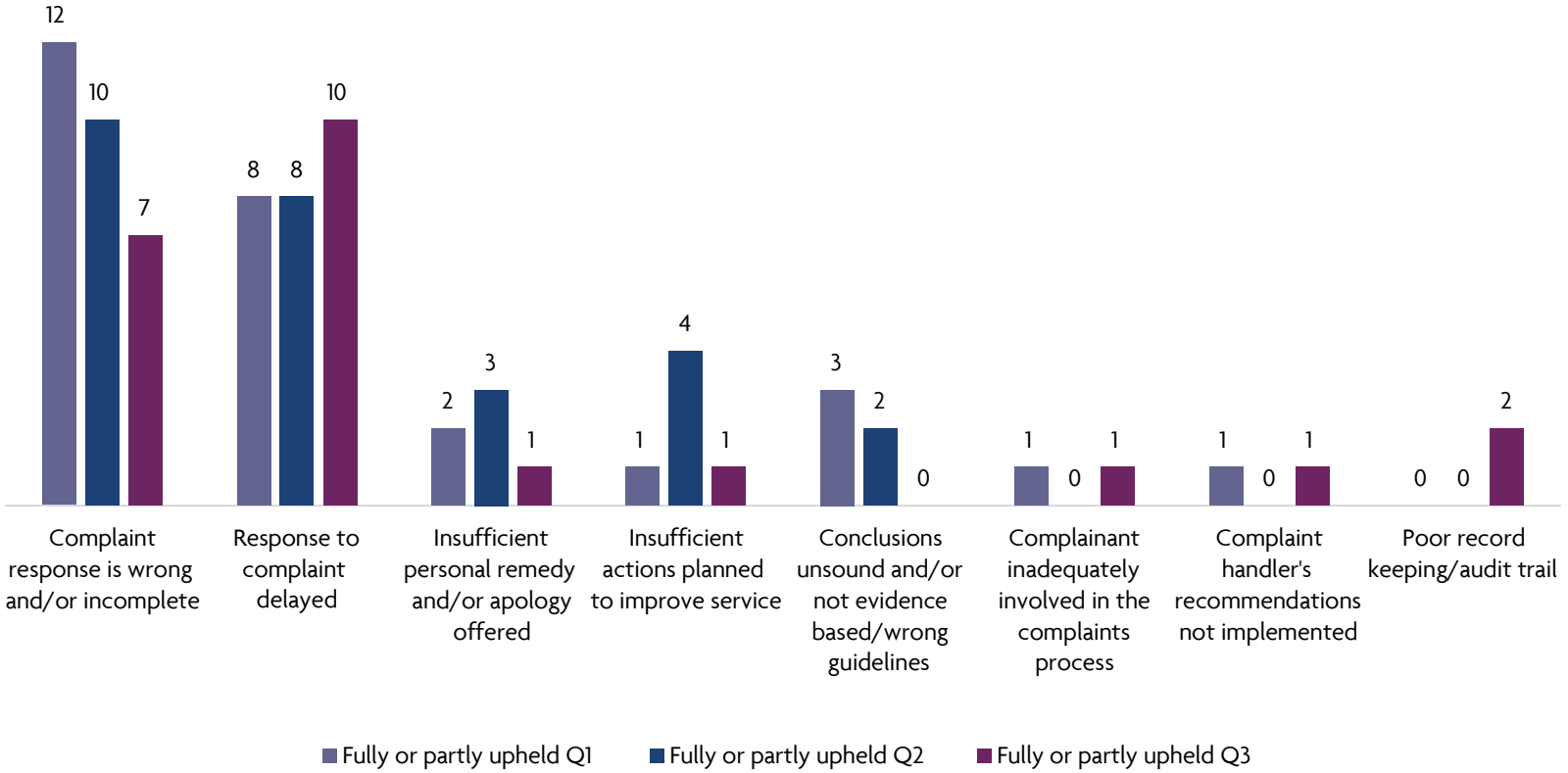
The most common complaint issue we fully or partly upheld in Quarter 3 in hospital and community health services was 'Access to treatment or drugs – other'. The number of complaint issues concerning 'Access to treatment or drugs – other' that we fully or partly upheld was **40** in Quarter 3 compared to **40** in Quarter 2, and **21** in Quarter 1.



Complaint handling

Chart 8 shows the different categories of complaint handling issues that were brought to us as complaints for health organisations for cases completed in Quarter 3.

Chart 8: Upheld complaints for health organisations by complaint handling issue, Quarter 1 - Quarter 3 2018-19



Key findings: Complaint handling

Concerns around complaint responses being wrong or incomplete, and complaint responses being delayed are the two issues that featured most frequently in complaints we fully or partly upheld about complaint handling during all three quarters in 2018-19.

Your feedback

In our three-year strategy for 2018-21 we have committed to becoming a more transparent organisation and our ambition is to develop the data and the trend analysis we publish in our quarterly reports.

We would welcome your views on how we can improve these reports and you can share any comments or feedback by emailing researchteam@ombudsman.org.uk

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